U.S. Department of Labor

Office of Administrative Law Judges
800 K Street, NW, Suite 400-N
Washington, DC 20001-8002

(202) 693-7300
(202) 693-7365 (FAX)

Issue Date: 11 July 2007

In the Matter of
H. H.
Widow of F. H.
Claimant

Case No. 2006-BLA-05985

v.

CONSOLIDATION COAL
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party-in-Interest

APPEARANCES:[1]
Joseph Wolfe, Esquire
For the Claimant
Ashby Dickerson, Esq.
For the Employer

BEFORE: DANIEL F. SOLOMON
Administrative Law Judge

DECISION AND ORDER

DENIAL OF BENEFITS

This matter arises from a claim for survivor's benefits filed by the Claimant as a survivor for benefits under the Black Lung Benefits Act, Title 30, United States Code, Sections 901 to 945 ("the Act"), as implemented by 20 C.F.R. Parts 718 and 725. Benefits are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis, or to survivors of persons who die due to pneumoconiosis. Pneumoconiosis is a dust disease of the lung arising from coal mine employment and is commonly known as "black lung" disease.

[1] The Director, Office of Workers' Compensation Programs, was not present nor represented by counsel at the hearing.

PROCEDURAL HISTORY

The Miner filed a claim on May 31, 1983. The claim was denied on modification by Administrative Law Judge E. Earl Thomas and on appeal by the Benefits Review Board ("BRB" or "Board") on March 18, 1993. The Claimant failed to establish any of the medical bases.

After he passed away on June 8, 2005, the miner's spouse filed a claim for survivor's benefits on August 8, 2005. (Director's Exhibit, "DX" 2). A Proposed Decision and Order awarding survivor's benefits was issued on March 11, 2006. (DX 28) On April 5, 2006, the Employer submitted a request for a hearing. The case was assigned to me and I held a telephone conference on April 11, 2007, and a hearing in Abingdon, on April 25, 2007 (Transcript, "TR) in Big Stone Gap, Virginia. Claimant was too ill to appear and an oral hearing was waived. Thirty three Director's exhibits, DX 1-DX 33 were admitted into evidence, TR 5. Seventeen Employer's exhibits, "EX" 1 – EX 17, were also admitted, TR 7.

APPLICABLE STANDARDS

Because the Claimant filed this application for benefits after March 31, 1980, the regulations set forth at part 718 apply. This claim is governed by the law of the United States Court of Appeals for the Fourth Circuit, because the Claimant was last employed in the coal industry in the Commonwealth of Virginia (Bishop Mining in Bishop, Virginia) within the territorial jurisdiction of that court. ***Shupe v. Director*, OWCP**, 12 B.L.R. 1-200 (1989) (en banc).

This case represents a survivor's claim for benefits. In order to receive benefits, the claimant must prove: (1) that the miner had pneumoconiosis, (2) the miner's pneumoconiosis arose out of coal mine employment, and (3) the miner's death was due to pneumoconiosis. 20 C.F.R. § 718.205(a). A miner's death was due to pneumoconiosis if: (1) competent medical evidence establishes that the miner's death was due to pneumoconiosis, (2) pneumoconiosis was a substantially contributing cause or factor leading to the miner's death or the death was caused by complications of pneumoconiosis, or (3) the presumption for complicated pneumoconiosis at § 718.304 is applicable. 20 C.F.R § 718.205(c)(1) – (3). However, survivors are not eligible for benefits where the miner's death was caused by a traumatic injury or the principal cause of death was a medical condition not related to pneumoconiosis, unless the evidence establishes that pneumoconiosis was a substantially contributing cause of death. 20 C.F.R. § 718.205(c)(4).

A "substantially contributing cause" is any condition that hastens the miner's death. 20 C.F.R. § 718.205(c)(5). Any condition that hastens the miner's death is a substantially contributing cause of death for purposes of § 718.205.

In a survivor's claim under Part 718, the claimant must demonstrate that pneumoconiosis "hastened" the miner's death "in any way.", ***Richardson v. Director, OWCP***, 94 F.3d 164 (4th Cir. 1996);***Shuff v. Cedar Coal Co***., 967 F.2d 977 (4th Cir. 1992), *cert. denied*, 113 S. Ct. 969 (1993).

STIPULATIONS AND WITHDRAWAL OF ISSUES

1. The Employer has stipulated to twenty four (24) years of coal mine employment. (TR at 8-9).
2. The person upon whose death or disability the claim is based is a miner. TR 8.

3. The Claimant is a widow of the miner and a dependant of the miner, thus qualifying as a survivor. TR 8.
4. The Responsible Operator has secured the payment of benefits. TR 8.

I have reviewed all of the evidence in the record and I accept the stipulations as they are consistent with the evidence.

ISSUES

1. Whether the miner had pneumoconiosis.
2. If so, whether pneumoconiosis arose out of coal mine employment.
3. Whether the miner's death was due to pneumoconiosis.

BURDEN OF PROOF

"Burden of proof," as used in this setting and under the Administrative Procedure Act[2] is that "[e]xcept as otherwise provided by statute, the proponent of a rule or order has the burden of proof." "Burden of proof" means burden of persuasion, not merely burden of production. 5 U.S.C. § 556(d).[3] The drafters of the APA used the term "burden of proof" to mean the burden of persuasion. ***Director, OWCP, Department of labor v. Greenwich Collieries [Ondecko]***, 512 U.S. 267, 18 B.L.R. 2A-1 (1994).[4]

A Claimant has the general burden of establishing entitlement and the initial burden of going forward with the evidence. The obligation is to persuade the trier of fact of the truth of a proposition, not simply the burden of production; the obligation to come forward with evidence to support a claim. Therefore, the Claimant cannot rely on the Director to gather evidence. The Claimant bears the risk of non-persuasion if the evidence is found insufficient to establish a crucial element. ***Oggero v. Director, OWCP***, 7 B.L.R. 1-860 (1985).

MEDICAL EVIDENCE

The parties did not designate any pulmonary function studies, blood gas studies, or any autopsy or biopsy evidence.

Death Certificate

Date of Certificate	Physician/Facility	EXH.
8/10/05	Brian E. Maggard, M.D.	DX 12

The Certificate notes respiratory failure as primary and coal workers' pneumoconiosis as secondary.

Medical Reports

Gregory Fino, M.D., board certified in internal medicine and pulmonology, reviewed records for the Employer. He determined there was no evidence of pneumoconiosis and no evidence to show cause of death. EX 1.

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[2] 33 U.S.C. § 919(d) ("[N]otwithstanding any other provisions of this chapter, ant hearing held under this chapter shall be conducted in accordance with [the APA]; 5 U.S.C. § 554(c)(2). Longshore and Harbors Workers' Compensation Act ("LHWCA") 33 U.S.C. § 901-950, is incorporated by reference into Part C of the Black Lung Act pursuant to 30 U.S.C. § 932(a).

[3] The Tenth and Eleventh Circuits held that the burden of persuasion is greater than the burden of production, ***Alabama By-Products Corp. v. Killingsworth***, 733 F.2d 1511, 6 B.L.R. 2-59 (11th Cir. 1984); ***Kaiser Steel Corp. v. Director***, OWCP [Sainz], 748 F.2d 1426, 7 B.L.R. 2-84 (10th Cir. 1984). These cases arose in the context where an interim presumption is triggered, and the burden of proof shifted from a Claimant to an employer/carrier.

[4] Also known as the risk of non-persuasion, *see* 9 J. Wigmore, Evidence § 2486 (J. Chadbourn rev. 1981).

James Castle M.D., also board certified in internal medicine and pulmonology , reviewed medical records. Dr. Castle noted the coal mine employment and noted that it is competent to produce pneumoconiosis. However, he also noted a 60 year smoking history of between one and two packs of cigarettes daily. He rendered the following opinion:

> It is my opinion that his death was caused by respiratory failure due to tobacco smoke induced pulmonary emphysema. It is my opinion he died as and when he would have regardless of his previous coal mine working history and whether or not he had coal workers' pneumoconiosis. It is my opinion with a reasonable degree of medical certainty that his death was not caused by, contributed to, or hastened by coal workers' pneumoconiosis. His death was due to tobacco smoke induced pulmoflaw emphysema.

EX 2.

"Other" Medical Evidence

Date of Scan	Physician/Facility	EXH.
7/8/04	Antoun	EX 17

CT scan: Emphysematous lungs with interstitial thickening on the mid-right hemithorax without CT findings of interathoracic abnormalities.

7/8/04	Wheeler	EX 17

CT scan: No pneumoconiosis. Emphysema.

Hospitalization Records/Treatment Notes

Date of Exam	Physician/Facility	EXH.[5]
6/23/00	J. Brookins Taylor	DX 14, EX 3

Office visit. Advised to quit smoking. Diagnoses include "severe pulmonary problems:" bronchitis, bronchial asthma, pulmonary infection, possible tumor of lung and abdomen.

12/16/01,1/25, 4/3/02	Tazewell Community Hospital/ Dr. Antoun	DX 14

Portable chest x-rays show emphysema and a 2.5 cm density.

10/28, 10/30/01	Tazewell Community Hospital/ Dr. Antoun/	EX 4

X-ray film: emphysematous lungs with chronic bibasilar infiltrates.

1/17-1/21/02	Tazewell Community Hospital/ Dr. Kwun	DX 14, EX 5

Admitted with shortness of breath. History of COPD (chronic obstructive pulmonary disease). Given oxygen, Albuterol and Atrovent. Discharge notes COPD with acute exacerbation.

10/8/03-10/15/03	Tazewell Community Hospital / Dr. Rinehart, M.D.	DX 14, EX 6

Hospitalized for shortness of breath. History notes advanced COPD/pneumoconiosis.Includes x-ray: consolidation present. Discharge diagnoses include "COPD/Tobacco abuse/pneumoconiosis."

10/13/03	Tazewell Community Hospital/ Dr. Antoun	DX 14

CT scan: minimal partial consolidation in right hemothorax.

10/25/03	Tazewell Community Hospital/ Dr. Antoun	DX 14

CT scan: persistent infiltrates in right hemothorax.

7/1/04	Tazewell Community Hospital/ Dr. Antoun	DX 14

CT scan: emphysema with "very minimal chronic fibrosis"

7/6/04	Tazewell Healthcare/Dr. Maggard	DX 13, DX 14

The miner has a "long history" of Black Lung. He has shortness of breath, had been seen at the ER five days prior, he was wheelchair bound. Diagnosis includes pneumoconiosis and a long smoking history. Discharge diagnosis includes "acute exacerbation of chronic obstructive pulmonary disease".

7/8/04	Tazewell Community Hospital/ Dr. Maggard	DX 13, DX 14

CT scan positive for emphysema. No mention of pneumoconiosis.

[5] Please note that any resemblance to the actual exhibit numbers and description of the evidence provided to me by the parties is merely coincidental.

7/8/04	Tazewell Community Hospital/ Dr. Antoun	DX 14

CT scan negative.

3/6-3/7/05	Tazewell Community Hospital/Dr. Maggard	DX 13

The Miner was hospitalized for a three day episode of shortness of breath . During the hospitalization, he was given a physical examination and discharge includes acute exacerbation of COPD.

4/1/05	Tazewell Community Hospital	DX 14, EX 7, EX 8, EX 9

Emergency visit due to shortness of breath. Includes Dr. Antoun x-ray report: portable x-ray compared with 3/5/05: since previous exam increasing haziness in right lung base with intersal thickening bilaterally basally suggestive of mild pulmonary edema with questionable infiltrates in right tower lobe; emphysematous lungs.

5/29/05	Tazewell Community Hospital	EX 10-EX 13

Emergency room physician notes history of COPD and smoking. Shortness of breath, malaise, moderate productive white sputum, rapid respirations. Diagnosis: COPD exacerbation. Given prednisone.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Existence of Pneumoconiosis

Pneumoconiosis is defined as a chronic dust disease arising out of coal mine employment.[6] The regulatory definitions include both clinical (medical) pneumoconiosis, defined as diseases recognized by the medical community as pneumoconiosis, and legal pneumoconiosis, defined as any chronic lung disease. . .arising out of coal mine employment.[7] The regulation further indicates that a lung disease arising out of coal mine employment includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment." 20 C.F.R. § 718.201(b).

A living miner can demonstrate the presence of pneumoconiosis by: (1) chest x-rays interpreted as positive for the disease (§ 718.202(a)(1)); or (2) biopsy report (§ 718.202(a)(2)); or the presumptions described in Sections 718.304, 718.305, or 718.306, if found to be applicable; or (4) a reasoned medical opinion which concluded the disease is present, if the opinion is based on objective medical evidence such as blood-gas studies, pulmonary function tests, physical examinations, and medical and work histories. (§ 718.202(a)(4)).

X-ray Evidence

Neither party identified any x-ray evidence. There are x-rays contained in treatment records but because they were not identified for evaluation, I will not use them.

Biopsy and Presumption

Claimant has not established pneumoconiosis by the provisions of subsection 718.202(a)(2) since no biopsy evidence has been submitted into evidence. None of the presumptions apply.

Medical Reports

20 C.F.R. § 718.202(a)(4) sets forth:

> A determination of the existence of pneumoconiosis may also be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in Section

[6] 20 C.F.R § 718.201(a).
[7] 20 C.F.R. § 718.201(a)(1) and (2) (emphasis added).

718.201. Any such finding shall be based on objective medical evidence such as blood-gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion.

The Claimant does not offer any medical report.

Other Evidence

Both parties submit readings of a CT scan dated July 8, 2004.

Rationale

I have reviewed all of the evidence relating to pneumoconiosis together, and I find that the Claimant has not established pneumoconiosis. The presence of pneumoconiosis is based on weighing all types of evidence under 20 C.F.R. § 718.202 together. ***Island Creek Coal Co. v. Compton***, 211 F.3d 203 (4th Cir. 2000).

There is no evidence to justify a finding of clinical pneumoconiosis. There were no x-rays for designated for evaluation. The CT sacn does not establish pneumoconiosis. The proponent of "other" evidence must establish that it is medically acceptable and relevant to entitlement. ***Webber v. Peabody Coal Co***, 23 B.L.R. 1-123 (2006)(en banc) (J. Boggs, concurring); 20 C.F.R. § 718.107(b). Both parties have failed to do so. Moreover, even if I had accepted it, the CT scan does not identify pneumoconiosis.

The Claimant asks me to incorporate all of the treatment records and the death certificate in making my determination. It is true that the death certificate lists pneumoconiosis as a cause of death. By listing pneumoconiosis it is reasonable that Dr. Maggard diagnosed pneumoconiosis.

However, a physician's conclusory statement on a death certificate, without further elaboration, is insufficient to meet Claimant's burden as to the cause of death. ***Bill Branch Coal Corp. v. Sparks***, 213 F.3d 186, 192 (4th Cir. 2000). The treating physician may be required to provide more than a conclusory statement before finding that pneumoconiosis contributed to the miner's death. It should be noted that a death certificate, in and of itself, is an unreliable report of the miner's condition and it is error to accept conclusions contained in such a certificate where the record provides no identification that the individual signing the death certificate possessed any relevant qualifications or personal knowledge of the miner from which to assess the cause of death. ***Smith v. Camco Mining, Inc.***,13 B.L.R. 1-17 (1989); ***Addison v. Director, OWCP***, 11 B.L.R. 1-68 (1988).

I assume the same is true as to a diagnosis of pneumoconiosis. The Claimant argues that a review of the record and records obtained from Tazewell Community Hospital include "recurring notes regarding the Claimant's long history of COPD related to his coal mine employment." I am directed to treatment from 2000 to death for shortness of breath. On the 8th of October, 2003 Dr. Stephen Rinehart noted that a physical examination on admission revealed Claimant's "breath sounds are particularly coarse with rales in the right mid and lower chest area." (DX 14). Blood gas study results on discharge show that the Claimant had a pCO2 of 42.8 and a p02 of 57.4. (DX-14) Dr. Brian Maggard on the 6th of July, 2004 notes the Claimant history of "black lung, degenerative joint disease; degenerative disk disease; gastroesophageal reflux disease; COPD; abdominal pain; hx of colon cancer." (DX-13). The Claimant submits that the treatment records establish his totally disabling pneumoconiosis and the necessary and aggressive treatment he received.

However, the record does not support a conclusion that the diagnosis justifies a finding of legal pneumoconiosis. In ***Richardson v. Director, OW***CP, 94 F.3d 164 (4th Cir. 1996), the court reiterated that "[c]linical pneumoconiosis is only a small subset of the compensable afflictions that fall within the definition of legal pneumoconiosis under the Act" and that "COPD, if it arises out of coal mine employment, clearly is encompassed within the legal definition of pneumoconiosis, even though it is a disease apart from clinical pneumoconiosis." See **Barber v. Director, OWCP**, 43 F.3d 899 (4th Cir. 1995) and ***Dehue v. Director, OWCP***, 65 F.3d 1189 (4th Cir. 1995).

I note that neither Dr. Castle nor Dr. Fino evaluated the record for legal pneumoconiosis. *See* ***Hobbs v. Clinchfield Coal Co.,*** 45 F.3d 819 (4th Cir. 1995) ("a medical diagnosis of no pneumoconiosis is not equivalent to a legal finding of no pneumoconiosis").

Although Dr. Maggard does refer to coal worker's pneumoconiosis in a July 6, 2004, report (DX 13), this report does not provide any documentation or reasoning to support this finding. Although I note a history of pneumoconiosis in the record and although I note that there is a diagnosis listed on an October, 2003 discharge summary: "COPD/Tobacco abuse/pneumoconiosis," I note that Dr. Maggard was not the attending physician at that time. DX 14. A medical history is usually provided by the patient, unless there has been an established diagnosis of record. Therefore, I find that Dr. Maggard's opinion is not based on objective medical evidence such as blood-gas studies, pulmonary function tests, physical examinations, and medical and work histories.

Moreover, Claimant failed to provide a diagnosis of *legal* pneumoconiosis. A review of the treatment records does not provide a substitution for a rationale of *legal* pneumoconiosis. Therefore, I find that the diagnosis on the death certificate was not based on a reasoned medical opinion. 20 CFR § 718.202(a)(4). ***Fields v. Island Creek Coal Co***., 10 B.L.R. 1-19 (1987). The Claimant failed to meet the burden of persuasion. ***Director, OWCP, Department of labor v. Greenwich Collieries [Ondecko]***, *supra*. See also ***Bill Branch Coal Corp. v. Sparks***, *supra*.

Therefore, I find that the Claimant failed to establish the existence of pneumoconiosis. 20 CFR § 718.202(a).

CONCLUSION

In summary, Claimant has failed to establish the presence of pneumoconiosis. This is a necessary element of claim and there is no reason to consider the other issues. ***Oggero v. Director, OWCP***, *supra*. Accordingly, Claimant is not eligible for benefits under the Act and regulations.

Attorney Fees

The award of attorney's fees under the Act is permitted only in cases in which Claimant is found to be entitled to benefits. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to Claimant for services rendered him in pursuit of this claim.

ORDER

It is hereby **ORDERED** that the claim of **H.H.** is **DENIED**.

A

DANIEL F. SOLOMON
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.478 and 725.479. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481. If an appeal is not timely filed with the Board, the decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).